

NEW PATIENT PACKET

General Information

Name:	Drug Allergies:
Date of Birth: SS#:	
Address:	
City: Zip:	
Phone (home): (other):	

Reason for Visit (briefly describe)

Surgeries and Major Procedures

Date	Reason	Date	Reason

Medications

Are you currently taking medications from other physicians? (Yes / No)

If yes, please list the physician's names: _____ Date: _____

Initials _____

Citizenship Verification

	Yes	No
The patient is a lawful citizen/resident of the United States or holds a valid visa.		
If "YES" provide a photocopy of a valid identification document (ID) such as driver license, American passport, foreign passport with valid visa, green card or permanent resident card, etc. Ask in reception for other valid identification forms. This verification, along with a photocopy of the ID document obtained, will be on file for all patients.		
Name-Please print:		
Signature:		
Date:		

(If patient is under 18 years of age, skip this section)

If you provide false information on this section, you will be subject to penalties of perjury.

Important Screenings and Exams

Colonoscopy Mammogram Pap Smear	Year of Last	DEXA/Bone Density Scan Prostate Exam (Males) Other: _____	Year of Last
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Vaccination History

Flu Pneumonia	Year of Last	Tetanus Other: _____	Year of Last
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Medical History (Check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Jaundice/Hepatitis
<input type="checkbox"/> Constipation
<input type="checkbox"/> STD
<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis/Rheumatism
<input type="checkbox"/> Gout
<input type="checkbox"/> Tetanus
<input type="checkbox"/> Herpes
<input type="checkbox"/> Failing Vision
<input type="checkbox"/> Swollen Ankles
<input type="checkbox"/> Gall Bladder Trouble
<input type="checkbox"/> Bloody or Tarry Stools
<input type="checkbox"/> Overnight Urination-frequent
<input type="checkbox"/> Foot Pain/Numbness
<input type="checkbox"/> Measles
<input type="checkbox"/> Psoriasis/Eczema | <input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Hair Loss
<input type="checkbox"/> Persistent Nausea/Vomiting
<input type="checkbox"/> Abdominal Pain Chronic
<input type="checkbox"/> Anemia
<input type="checkbox"/> Hay Fever/Allergies
<input type="checkbox"/> Vaginal/Penile Discharge
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Prostate Disease
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Rashes/Hives
<input type="checkbox"/> Eye Infection
<input type="checkbox"/> Leg Pain - Walking
<input type="checkbox"/> Change in Bowel Habits
<input type="checkbox"/> Urinary Infections- Frequent
<input type="checkbox"/> Decreased flow urination
<input type="checkbox"/> Dairy/Lactose Intolerance
<input type="checkbox"/> Mumps
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hernia
<input type="checkbox"/> Urination Probs/Freq
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chronic Fatigue
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Back Pain Recurrent
<input type="checkbox"/> Sexual Dysfunction
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Sore Throat -Frequent
<input type="checkbox"/> Varicose Veins/Phlebitis
<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Rubella | <input type="checkbox"/> Ear Infections <i>frequent</i>
<input type="checkbox"/> Indigestion/heartburn
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Weight Loss - Recent
<input type="checkbox"/> Convulsions/Seizures
<input type="checkbox"/> Headaches Frequent
<input type="checkbox"/> Bone Fracture/Joint Injury
<input type="checkbox"/> Menstrual Dysfunction
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ringing in ear
<input type="checkbox"/> Bronchitis-chronic cough
<input type="checkbox"/> Peptic Ulcers
<input type="checkbox"/> Crohn's/Colitis
<input type="checkbox"/> Urination loss of control
<input type="checkbox"/> Tremor-Hands Shaking
<input type="checkbox"/> Polio
<input type="checkbox"/> Scarlet Fever |
|---|--|--|--|

Lifestyle/Demographics

1. What is your current marital status?

- ☐ *Single*
- ☐ *Married*
- ☐ *Divorced*
- ☐ *Widowed*

2. How many marriages have you had? _____

3A. Are you (check all that apply)?

- ☐ *Hispanic/Latino*
- ☐ *Non Hispanic/Latino*
- ☐ *American Indian/Alaska N.*
- ☐ *Asian*
- ☐ *Black/African American*
- ☐ *Pacific Islander/Hawaiian N.*
- ☐ *White/Caucasian*
- ☐ *Other (specify) _____*

3B. What is your primary language?

- ☐ *English*
- ☐ *Spanish*
- ☐ *Other (specify) _____*

4. Please select your average weekly exercise.

- ☐ *Less than once a week*
- ☐ *1-3 Times a week*
- ☐ *4-7 Times a week*
- ☐ *More than 7 times a week*
- ☐ *Other: _____*

5. Please indicate the types of exercise you do:

- ☐ *Walking*
- ☐ *Running*
- ☐ *Biking*
- ☐ *Swimming*
- ☐ *Aerobics*
- ☐ *Weight Lifting*
- ☐ *Other: _____*

6. Please describe your eating habits.

- ☐ *Fairly Balanced*
- ☐ *Eat too much*
- ☐ *Lots of fast food*
- ☐ *I follow a diet program*
- ☐ *Other: _____*

7. Have you or your partner had intimate contact with a: male homosexual, I.V. drug user, or someone with AIDS?

- ☐ *No*
- ☐ *Yes*
- ☐ *I don't know*

8. Do you drink alcohol?

- ☐ *No*
- ☐ *Yes*
- ☐ *Former Drinker*

Please elaborate if necessary:

9. Do you use tobacco?

- ☐ *No*
- ☐ *Yes*
- ☐ *Former Smoker*

If yes, how often?

10. Do you use recreational drugs?

- ☐ *No*
- ☐ *Yes*
- ☐ *Former Drug User*

Please elaborate if necessary:

11. Do you need a doctor's help with drug addiction?

- ☐ *No*
- ☐ *Yes*

Please elaborate if necessary:

12. Have you ever been sexually abused?

- ☐ *No*
- ☐ *Yes*

Please elaborate if necessary:

13. Have you ever been physically abused?

- ☐ *No*
- ☐ *Yes*

☐ Please elaborate if necessary:

14. Have you ever been emotionally abused?

- ☐ *No*
- ☐ *Yes*

Please elaborate if necessary:

14. Please check the most recent education you have completed.

- ☐ *High School graduate or equivalent*
- ☐ *Trade School*
- ☐ *Some College*
- ☐ *College Graduate*
- ☐ *Post Graduate*
- ☐ *Other: _____*

15. What is your occupation?

Females (Please Complete the following)

16. Have you ever been pregnant?

- ☐ *No*
- ☐ *Yes*

17. Have you ever had a Miscarriage?

- ☐ *No*
- ☐ *Yes*

18. Live birth(s) with complications?

- ☐ *No*
- ☐ *Yes*

19. When was your last menstrual Period?

20. What methods of birth control do you use?

Comments:

Family History

Are you adopted? (Yes / No)

Please indicate if any immediate family members have had any of the following conditions:

	Father	Mother	Children	Siblings	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Substance abuse								
Alzheimer's Disease/Dementia:								
Cancer: (If yes, please indicate what type of cancer).								
Diabetes:								
Emotional / Mental Illness:								
Suicide:								
High Blood Pressure:								
Heart Attack Prior To age 55:								
Heart Disease:								
Thyroid Disease:								
Osteoporosis:								
Stroke:								
Tuberculosis:								
Kidney Disease:								
Epilepsy / Convulsions								
Other non-accidental deaths prior to age 50:								

INSURANCE INFORMATION

Patients Name:		SS:	
Address:			
Phone #:	DOB:	Age:	Sex:
Employer:		Relationship to insured:	
Primary Insurance			
Insured's name:			
SS:			
Address:			
Phone #:	DOB:	Age:	Sex:
Employer:		Relationship to Insured:	
Insurance Company:			Phone #:
Address:			
Id:		Group #:	
Secondary Insurance			
Insured's name:			
SS:			
Address:			
Phone#:	DOB:	Age:	Sex:
Employer:		Relationship to Insured:	
Insurance Company:			Phone #:
Address:			
Id #:		Group #:	

Emergency Contact:

Name: _____ Phone # _____

Relation to patient: _____

Contact Record:

Can we contact you by: (Please circle all that apply)

Telephone (cell/home)
Work Telephone
Written Communication

Yes or No
Yes or No
Yes or No

May we leave a message?
May we leave a message?
Mail to:

Yes or No
Yes or No
Home or Work

PLEASE READ CAREFULLY BEFORE SIGNING
Authorization for Medical and/or Surgical Treatment

This is to certify that I, the undersigned hereby consent to and authorize the administration and performance of all treatment and which in the judgment of the attending physician/practitioner may be considered necessary or advisable. I also authorize treatment of any of my minor children herein listed.

(Signature of Patient/Authorized Representative)

Date

AGREEMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible amount, co-insurance, or any services deemed as "Non-Covered Benefit" by my insurance carrier. A finance charge of 1.5% per month/APR 18% may be added to any amount for which payment has not been received within 30 days from the date of service. I agree to pay a \$20.00 service charge for any returned check as unobtainable. Also if any check is returned as unobtainable, any discounts given to me at the time the check was issued shall be void and such discount shall become due and payable.

INSURANCE BILLING

In the event that I have a third-party payer herein listed, I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid Private Insurance and any other health plan to **Health Clinics of Utah**. This assignment will remain in effect until revoked by me in writing, A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said third party payer. I hereby authorize said assignee to release all information necessary to secure payment.

I agree to notify **Health Clinics of Utah** in writing of any changes in employment, address, marital status, insurance carrier(s), insurance coverage, minor children and/or dependents herein listed as beneficiary, minor children on their 18th birthday, or minor children no longer living at my residence. I agree to relate this information to **Health Clinic(s) of Utah** within 30 days of such event(s) occurring.

GOVERNMENTAL IMMUNITY. All claims for negligence, and other claims against Health Clinics of Utah and its employees, including physicians, nurses, technicians and students, may be governed by the provisions of the Utah Governmental Immunity Act, Section 63-30-1 et seq. Utah Code Annotated, 1953 as amended, a special law restricting how and when a claim must be presented and limitations on the amount recovered.

I acknowledge that I have carefully read that above and hereby agree to the terms and conditions as set forth. I have had the opportunity to ask questions and if so, understand the answers.

(Signature of Patient/Authorized Representative)

Date

Witness

Date

STATE OF UTAH DEPARTMENT OF HEALTH
FAMILY DENTAL PLAN (FDP) AND HEALTH CLINICS OF UTAH (HCU)
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
Effective: 04/14/2003

The FDP/HCU is committed to protecting your medical information. FDP/HCU is required by law to maintain the privacy of your medical information, provide this notice to you, and abide by the terms of this notice.

HOW WE USE YOUR HEALTH INFORMATION

When you receive care from FDP/HCU, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information include:

TREATMENT - We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. Some health records, including confidential communications with a mental health professional, substance abuse treatment records, and genetic tests results, may have additional restrictions for use and disclosure under state and federal laws.

PAYMENT - We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company.

HEALTH CARE OPERATIONS - We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

OTHER SERVICES WE PROVIDE

We may also use your health information to recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends involved in your care or payment for your care, share information with third parties who assist us with treatment, payment, and health care operations, and remind you of an appointment.

OPTIONAL: notify the scheduler if you do not wish to be reminded.

YOUR INDIVIDUAL RIGHTS

YOU HAVE THE RIGHT TO:

- ☐ Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction.
- ☐ Request that we use a specific telephone number or address to communicate with you.
- ☐ Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial. *
- ☐ Request corrections or additions to your health information. *
- ☐ Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations, and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period. *

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- ☐ Request a paper copy of this notice even if you agree to receive it electronically. Requests marked with a star (*) must be made in writing. Contact the FDP (dental requests) or HCU (medical requests) privacy officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include activities necessary to administer the Medicaid program and the following:

- ☐ For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices.
- ☐ To protect victims of abuse, neglect, or domestic violence.
- ☐ For health oversight activities such as investigations, audits, and inspections.
- ☐ For lawsuits and similar proceedings.
- ☐ When otherwise required by law.
- ☐ When requested by law enforcement as required by law or court order.
- ☐ To coroners, medical examiners, and funeral directors.
- ☐ For organ and tissue donation.
- ☐ For research approved by our review process under strict federal guidelines.
- ☐ To reduce or prevent a serious threat to public health and safety.
- ☐ For workers' compensation or other similar programs if you are injured at work.
- ☐ For specialized government functions such as intelligence and national security.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

OUR PRIVACY RESPONSIBILITIES

FDP/HCU IS REQUIRED BY LAW TO:

- ☐ Maintain the privacy of your health information.
- ☐ Provide this notice that describes the ways we may use and share your health information.
- ☐ Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in FDP/HCU offices and on our website. You may also request a copy of any notice from the FDP (dental requests) or HCU (medical requests) privacy officer listed below:

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information contact the:

FDP Privacy Officer (dental), Butch Luers, Ph: 801-273-6642, or e-mail bluers@utah.gov.

HCU Privacy Officer (medical), Rett Hansen, Ph: 801-626-3671, or e-mail retthansen@utah.gov.

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Region VIII, Office for Civil Rights, U.S. Department of Health and Human Services, 1961 Stout Street - Room 1185 FOB, Denver, CO 80294-3538

By Signing below, I certify that I have had the Notice of Privacy Practice made available to me.

(Patient Name) Please Print

Date of Birth

(Signature of Patient / Authorized Representative)

Date

HEALTH CLINICS OF UTAH-SALT LAKE

168 N 1950 W #201, SLC UT 84116

Phone: 801-715-3500

Fax: 801-532-1183

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name

SS#

DOB ____/____/____

I, _____ hereby authorize
(Patient/Personal Representative)

(Name of hospital or office where records are being requested from)

(Phone Number)

(Fax Number)

to disclose specific health information from the records of the above named patient to:

Health Clinics of Utah-Salt Lake
168 N 1950 W #201, SLC UT 84116

The specific health information authorized for disclosure is: (include Dates of Service)

The purpose of the disclosure is:

I understand this authorization will expire on the following date, event, or condition:

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose. I understand that I may revoke this authorization at any time by sending written notification to Privacy Officer indicated in the Notice of Privacy practices previously received (a duplicate Notice of Privacy Practices is available upon request when filling out this authorization). I understand that a revocation is not effective to the extent that the Health Clinics of Utah has taken action in reliance on the authorization.

I understand the Health Clinics of Utah cannot condition treatment, payment, and enrollment in a health plan, or eligibility for benefits on whether I sign this Authorization.

I understand that information disclosed pursuant to this authorization could be redisclosed by the recipient and no longer be protected by the federal medical privacy law.

(Signature of Patient/Authorized Representative)

(Date)

Authorized Representative's authority to act for patient (if applicable):

HEALTH CLINICS OF UTAH - SALT LAKE NO SHOW POLICY

Health Clinics of Utah-Salt Lake has a no show policy requiring patients to cancel their appointments 24 hours in advance. Failure to do so will result in a \$5 penalty fee that must be paid prior to scheduling any future appointments.

If you no-show an appointment with one of our volunteer specialists you may not be able to reschedule again with them.

Thank you,
Administration

(Signature of Patient/Authorized Representative)

(Date)